Illinois Department of Healthcare and Family Services

AGREEMENT FOR PARTICIPATION IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM FOR TRANSPORTATION PROVIDERS

WHEREAS, _____
Full Legal as well as any Assumed (d.b.a.) name,

_____ HFS Provider Number, if applicable) hereinafter referred to as ("the Provider") is enrolled with the Illinois Department of Healthcare and Family Services, hereinafter referred to as ("the Department"), as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider wishes to submit claims for services rendered to eligible HFS clients;

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program billing and policy provisions as set forth in the applicable Department of HFS Medical Assistance Program rules and handbooks.

2. The Provider agrees, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations.

3. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX and XXI of the Social Security Act and with all other applicable Federal and State laws and regulations.

4. The Provider agrees that any rights, benefits and duties existing as a result of participation in the Medical Assistance Program shall not be assignable without the written consent of the Department.

5. The Provider shall receive payment based on the Department's reimbursement rate, which shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from charges sent to the Department.

6. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to the Department for payment. Provider acknowledges that it understands the laws and handbook provisions regarding transportation services and certifies that the services will be provided in compliance with such laws and handbook provisions. Provider further acknowledges that compliance with such laws and handbook provisions is a condition of payment for all claims submitted. Any submittal of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.

7. The Provider agrees to furnish to the Department or its designee upon demand all records, associated with submitted claims necessary to disclose fully the nature and extent of services provided to individuals under the Medical Assistance Program and maintain said records for not less than three (3) years from the date of service to which it relates or for the time period required by applicable Federal and State laws, whichever is longer. The latest twelve months of records must be maintained on site. If a Department audit is initiated the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.

8. The Provider agrees that vehicle operator(s) shall have an appropriate Drivers License and vehicle(s) shall be properly registered and safely maintained in accordance with Department rules and handbook provisions.

9. The Provider agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.

10. The Provider agrees to exhaust all other sources of reimbursement prior to seeking reimbursement from the Department.

11. The Provider agrees to be fully liable to the Department for any overpayments, which may result from the Provider's submittal of billings to the Department. The Provider shall be responsible for promptly notifying the Department of any overpayments of which the Provider becomes aware. The Department shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the Department.

12. The Provider certifies that there has not been a prohibited transfer of ownership interest to or in the provider by a person who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12 B 4.25.

13. The Provider certifies that the following is a complete list of owners/stock holders owning 5% or more of the stock/shares. If additional space is needed for names, please use separate page. If there is no information to disclose, write NONE on PRINT NAME line. This section MUST be completed for enrollment purposes and an entry is required.

PRINT NAME	SOCIAL SECURITY NUMBER	% OF OWNERSHIP
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PRINT NAME	SOCIAL SECURITY NUMBER	% OF OWNERSHIP

14. The Provider agrees that every shareholder with 5% or more of the stock/shares, every partner in a partnership, the sole proprietor and each officer, manager and dispatcher shall submit to fingerprint based criminal background checks as provided in 89 Illinois Administrative Code Section 140.498.

15. The Provider certifies that the following is a complete list of every partner in a partnership, the sole proprietor and each officer, manager and dispatcher. If additional space is needed for names, please use separate page. This section MUST be completed for enrollment purposes and an entry is required.

PRINT NAME	SOCIAL SECURITY NUMBER	POSITION WITHIN COMPANY
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PRINT NAME	SOCIAL SECURITY NUMBER	POSITION WITHIN COMPANY

16. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws.

17. The Provider agrees and understands that enrollment of a non-emergency transportation vendor, as defined in 89 Illinois Administrative Code Section 140.13, shall be conditional for 180 days, during which time the Department may terminate such vendor's eligibility to participate in the Medical Assistance Program without cause. Such termination of eligibility is not subject to the Department's hearing process. Upon termination of the non-emergency transportation vendor, the following individuals shall be barred from participation in the Medical Assistance Program: individuals with management responsibility; all owners or partners in a partnership; an officer or individual owning, directly or indirectly, 5% or more of the shares of stock or other evidence of ownership in a corporation; or an owner of a sole proprietorship.

18. This agreement becomes effective the date the Department completes its review of the application for enrollment. No payment will be made for services rendered prior to the completion of the application's review. The provider certifies that all services will be rendered in compliance with and subject to the terms and conditions of this agreement.

Under penalties of perjury, the undersigned declares and certifies that the information provided in this Agreement for Participation is true, correct and complete.

DEPARTMENT of HEALTHCARE
AND FAMILY SERVICES:

by: _____ by: _____
(Provider Signature) Division of Medical Programs

_____
(Print Name of Signature above)

Date: _____ Date: _____